GENERAL AUTHORIZATION FOR RELEASE OF INFORMATION BY THE TENNESSEE DEPARTMENT OF HUMAN SERVICES TO A 3rd PARTY

Information will be released for: **PRINT NAME►**	**Date:**	**Identify Signer:** ☐ Self ☐Parent of minor ☐Guardian ☐Other authorized representative (explain) *Proof of legal authorization may be required.
Street Address		**(Parent/guardian sign here if two signatures required by State law)**

Phone Number (with area code) ( )	**City**	**State**	**Zip**

I, authorize the Tennessee Department of Human Services and its authorized agents/contractors, to release the following information from the records of the Department of Human Services described below:

- All records (*other than Medicaid/TennCare/Drug/Alcohol/Educational records****See Note Below**) Yes:_____ No: _____ ***OR***
- Families First or Food Stamp case records Yes:_____ No: _____
- Vocational Rehabilitation Services records Yes:_____ No: _____
- Other: Yes:_____ No: _____ Describe: _____

_____

_____

***NOTE: IF MEDICAL/HEALTH INFORMATION IS TO BE RELEASED, THE APPLICANT/RECIPIENT *MUST* COMPLETE A TDHS 3RD PARTY HIPAA RELEASE FORM. IF EDUCATIONAL RECORDS ARE TO BE RELEASED, THE EDUCATION AGENCY MAINTAINING THE RECORDS *MUST* BE CONTACTED DIRECTLY BY THE PERSON OR ENTIY SEEKING THE RECORDS.**

This information may be released to the following persons or organizations: *Enter either "All" or state specific persons/organizations or types of persons/organizations to whom information can be released.*

_____

_____

_____

For the records I have given permission to be disclosed, TDHS can talk to, or give copies of my records to any of the person/organizations I have permitted and can give this information by paper, fax, computer or electronic copies of those records.

YOU DO NOT HAVE TO SIGN THIS FORM. I understand that I am *not* required to give permission, *and* that my decision will *not* affect any benefits or services which I, my child or family are receiving from the Department of Human Services or for any benefits or services for which I have applied from the Department of Human Services.

- I will get a copy of this form after I sign it. I can ask TDHS to let me see a copy of the information it releases after I sign this form.
- **This permission is good for 12 months from the date I sign this form, unless I take back my permission sooner.**
- **You have the right to withdraw your permission at any time. *You cannot take back information that has been received from other persons/organizations if you choose to take back your permission it will not affect any actions taken before you take back your permission.***
- **To take back your permission to let us get your records from other persons/organizations, you can *write* TDHS in your county, or write the persons/organizations that you have said we can give your information to.**
- All information about you that TDHS gets is protected by the Privacy Act of 1974 and federal or state law or regulations. It will not be given to other persons or organizations unless the law or regulations allow or require us to give out that information, or you allow us to give out that information. If we are required or permitted to give out the information about your records, it may not be protected if the person or organization that receives it is not required by law to protect the information.
- Ask TDHS to explain if you have questions about the information that is to be released.

Signature of Person or Person's Authorized Representative: _____ Date:_____